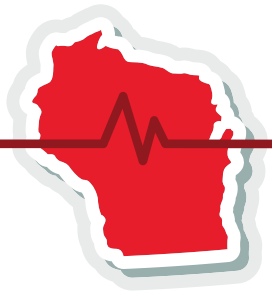
THE COSTLY CHRONIC DISEASE EPIDEMIC IN WISCONSIN



About the Partnership to Fight Chronic Disease

The Partnership to Fight Chronic Disease (PFCD) Wisconsin is a diverse coalition of patient, provider, and community organizations, business and labor groups, and health policy experts committed to raising awareness of the number one cause of death, disability, and rising health care costs in Wisconsin and nationwide: rising rates of preventable and treatable chronic diseases.

About this Platform

The PFCD believes that the growing prevalence and complexity of chronic health problems are becoming an unsustainable challenge for American families, our health care system and economy overall. Simply put, we cannot lessen rising health care costs and the economic losses of poor health without addressing chronic disease. Tackling these challenges relies on a willingness to adopt policies that help Americans better prevent and manage chronic illnesses. It is our hope that this platform will help to focus our nation's leaders – including the 2016 presidential candidates – on the crisis of chronic disease and highlight commonsense reforms to fight chronic disease and improve lives across Wisconsin and the nation.

The Costly Chronic Disease Epidemic Harms Wisconsin

- More than 1 in 2 adults in Wisconsin lives with at least one chronic condition – such as diabetes, heart disease, or depression – daily. And, nearly 1 in 3 have two or more chronic conditions.[1]
- The percentage of children with chronic health conditions has risen dramatically. For example, childhood obesity rates alone have more than tripled just since the 1970's.[2]
- Each chronic condition an individual has increases his or her medical spending by more than $2,000 a year on average.[3]
- In addition to increasing medical costs, the onset of just one chronic condition is estimated to reduce individv ual earnings by 12% at diagnosis and by 18% in the long-term.[4] Diabetes and arthritis alone cost families more than $116 billion a year in lost wages and other losses, not including medical costs.[5]
- Treating people with chronic diseases accounts for 86 cents of every dollar we spend on health care in the U.S.
- A mere 5 percent of the population accounts for more than half of all health care spending,[6] making targeted reforms a priority.
- The World Health Organization estimates that as much as 80 percent of premature heart disease, stroke, and type 2 diabetes and 40 percent of cancers could be avoided if Americans avoided tobacco, developed healthier eating habits, and were more physically active.[7]
- We could also better manage chronic conditions to prevent costly complications. Chronically ill Americans receive recommended preventive care services, such as tests, doctor visits and medicines, only about half (56 percent) of the time.[8]
- Innovation holds promise: a medical breakthrough that delayed the onset of Alzheimer's disease by just five years could prevent 5.7 million Americans from developing Alzheimer's and save $367 billion a year within the first 25 years of its availability.[9]

To realize the opportunity from improved prevention and management of chronic disease, the PFCD believes that America needs health care that

- **Prioritizes Prevention and Management of Chronic Conditions.**
- **Encourages Continued Innovation in Treatment and Delivery of Health Care.**
- **Improves Access to Recommended Care.**
- **Promotes Health Across Generations.**
- **Translates Knowledge into Action.**

We recommend commonsense, actionable reforms that will improve health for all Americans:

Opportunities to Prioritize Management and Prevention of Chronic Disease:

- Aligning incentives through carefully designed provider payment reforms that assure access to high-quality care, emphasize improving health outcomes for patients to lower the cost burden of poor health, and allow for continued innovation and support care personalized for patient needs and preferences.
- Encouraging increased coordination, continuity of care, and care management to facilitate the transition from an acute care, crisis model to one focused on disease prevention, early detection, and health management. Embracing care coordination will improve care, reduce errors and wasteful spending, and lessen disparities.
- Empowering and motivating Americans to prevent, detect and manage chronic diseases proactively by engaging people more directly in their health and addressing health literacy, socioeconomic issues, and other barriers to better health.
- Integrating the primary care provider more completely into the care management process, including behavioral health. The health care system is not organized in a way that fully supports primary care providers. Behavioral health services are mostly separated from the primary care system, a practice recognized by the Institute of Medicine nearly 20 years ago that leads to inferior care.[10]
- Improving coordination between traditional medical care system, public health, social services, and community resources. Poor health often reflects a constellation of issues related to housing, transportation, food insecurity, and other socioeconomic factors. The health care system will be more effective and more efficient if it embraces the resources available outside the medical system that support improved health.

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[1] IHS Life Sciences (2015).

[2] JM Perrin, SR Bloom, SL Gortmaker, "The Increase of Childhood Chronic Conditions in the United States," JAMA. 2007; 297(24): 2755-2759.

[3] AHRQ, Multiple Chronic Conditions Chartbook: 2010 MEPS Data.

[4] YK Chung, "Chronic Health Conditions and Economic Outcomes," Korea Energy & Econ Inst, Oct. 2013.

[5] CDC, Chronic Disease Overview. Available online at: http://www.cdc.gov/chronicdisease/overview

[6] SB Cohen, "The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions, 2012," AHRQ Statistical Brief #455 (Oct. 2014). Online at: http://meps.ahrq.gov/mepsweb/data_files/publications/st455/stat455.pdf

[7] World Health Organization. Chronic Diseases and Health Promotion. Overview – Preventing chronic diseases – a vital investment. Available at: http://www.who.int/chp/chronic_disease_report/part1/en/index11.html

[8] EA McGlynn, SM Asch, et al., "The Quality of Health Care Delivered to Adults in the United States," N Engl J Med 2003; 348:2635-2645.

[9] Alzheimer's Association. Changing the Trajectory of Alzheimer's Disease: How a Treatment by 2025 Saves Lives and Dollars https://www.alz.org/documents_custom/trajectory.pdf

[10] Institute of Medicine, *Primary Care: America's Health in a New Era* (Washington, D.C.: The National Academies Press, 1996.)

Opportunities to Encourage Continued Innovation in Treatment and Delivery of Health Care:

- Giving health care providers accurate, timely information at the point of care to deliver the highest quality, evidence-based medicine using health IT.
- Building systems that facilitate proactive management of patients with chronic illness.
- Aiding collaboration among care providers and between the public health and medical care systems by facilitating the interoperability of disease registries and information sharing.
- Supporting more effective coordination of care and ensuring access to patient and clinical information across care settings by maximizing health IT use and usefulness.
- Facilitating Americans' ability to track their own health and to obtain information on conditions, treatment options, and quality at the point of decision-making.
- Expanding participation in clinical trials.
- Supporting policies to incentivize biomedical innovation. Continued progress depends upon having an environment that encourages and rewards advances in detection, treatment, and care delivery.

Opportunities to Improve Access to Recommended Care:

- Removing barriers to comprehensive prevention, early detection, and intervention, and disease management resources in designing benefits and health care financing models.
- Ensuring that consumers have easy access to consumer-friendly information when selecting health insurance, including what is and is not covered and true out-of-pocket costs.
- Building the workforce of primary care providers in underserved areas and leveraging the full spectrum of health care workers to fill gaps, improve care access, and lower costs.
- Facilitating access to community-based services. Integrating community-based services more closely with the health care system can increase support for patients and families while reducing overall health care costs.

Opportunities to Improve Health across Generations:

- Promoting wellness in the workplace. Estimated savings from well-designed programs show that each dollar invested saves more than three dollars in medical costs and more than two and a half dollars in losses from missed work days.[11]
- Incorporating health promotion and disease prevention and management into the everyday routines of American children and families. Policies that improve access to safe places to be active, to encourage healthy food consumption, to avoid and cease tobacco use, to reduce exposure to harmful chemicals, and to empower healthy decisions through education and awareness can make a significant difference today and for future generations.
- Improving support for those with family caregiving responsibilities. Almost 80 percent of care at home is provided by unpaid family caregivers—many at the sacrifice of their own health.[12] These families need opportunities for respite care and social support networks, which can make the caregiver role more manageable.

Opportunities to Translate Knowledge into Action

In communities across Wisconsin, innovative programs work to promote wellness, and prevent and manage disease. We aren't doing enough to tap into that knowledge and replicate programs that work nationwide, particularly in underserved areas and populations in which health disparities persist in lowering health status and leading to lost economic opportunities.

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[11] K Baicker, D Cutler, and Z Song, "Workplace Wellness Programs Can Generate Savings," Health Affairs. 2010; 29(2):304-311.

[12] HHS, "LongTermCare.Gov: Who Will Provide Your Care?", http://longtermcare.gov/the-basics/who-will-provide-your-care/.

Preventing Chronic Diseases in At-Risk Populations: Diabetes Prevention Program

The well-tested Diabetes Prevention Program continues to generate significant results in preventing the onset of diabetes in people with pre-diabetes. Adapting the program to a lower-cost community setting has broadened the reach of the program and increased accessibility. Many private insurers and employers provide access to the program, but traditional Medicare currently does not. Offering the program to adults ages 60-64 at risk is estimated to save Medicare at least $7 billion over the lifetime of participants. The program, available in YMCA's in Wisconsin and other community venues, is also being tested as part of a Centers for Medicare and Medicaid Innovation grant in communities across the U.S.

Sources: http://cecp.co/membership/member-initiatives-2/item/70-unitedhealth-group-diabetes-prevention-and-control-alliance-dpca.html; http://www.ymca.net/diabetes-prevention; K Thorpe & Z Yang, "Enrolling People Age 60-64 with Pre-Diabetes in a Proven Weight Loss Program Could Save Medicare $7 Billion or More," Health Aff. 2011; 30(9): 1-7; For WI programs, visit http://www.ymca.net/diabetes-prevention/locate-participating-y (participating YMCAs) and https://nccd.cdc.gov/DDT_DPRP/Registry.aspx?STATE=WI (CDC-certified programs).

Empowering Chronic Disease Self-Management: Better Choices, Better Health™

This well-tested model relies on community-based or online workshops for people with chronic diseases led by peer coaches with health problems of their own. Workshops focus on building self-management skills, sharing experiences, and offering support. Consistent participant results include greater energy/reduced fatigue, more exercise, fewer social limitations, better well-being, enhanced partnerships with physicians, improved health status, and greater self-management skills. Participants also demonstrated more appropriate utilization of healthcare services that maintain even with declines in health, and cost-savings in reduced utilization of emergency care, hospitalizations, and other intensive services.

Sources: Stanford Univ, "Review of Findings on Chronic Disease Self-Management Program Outcomes: Physical, Emotional & Health-Related Quality of Life, Healthcare Utilization & Costs," 2008. http://patienteducation.stanford.edu/research/Review_Findings_CDSMP_Outcomes1%208%2008.pdf; for WI sites visit https://www.dhs.wisconsin.gov/aging/healthpromotion.htm.

Advancing Primary Care Delivery for Chronic Conditions: Marshfield Clinic

As a part of the Medicare Physician Group Practice demonstration, the Marshfield Clinic's successful approach to caring for people with chronic conditions saved Medicare $118 million over 5 years while achieving high marks on quality. The clinic's efforts rely on patient-centered medical homes. Specialized care management programs include individual care plans to enhance patient education and self-management skills, help in making lifestyle changes and increasing treatment adherence, and consistent monitoring and symptom management.

Sources: S Klein, et al., "Marshfield Clinic: Demonstrating the Potential of Accountable Care," The Commonwealth Fund, Oct. 2014, http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1771_klein_marshfield_clinic_aco_case_study.pdf

Enabling Aging in Place: Independence at Home Demonstration

Under the Independence at Home Demonstration, selected primary care practices, including the Visiting Physicians Association (VPA) in Milwaukee/West Allis, WI, provide in-home primary care to Medicare beneficiaries with multiple chronic conditions. Care plans are tailored to meet an individual patient's needs and preferences. In just the first year of this five-year demonstration, VPA generated nearly $900 per participant in savings for Medicare compared to projected costs.

Sources: CMS, Independence at Home Demonstration Fact Sheet," Oct. 2015, https://innovation.cms.gov/Files/fact-sheet/iah-fs.pdf; CMS, Independence at Home (IAH) Demonstration Year 1 Practice Results, June 2015, https://innovation.cms.gov/Files/x/iah-yroneresults.pdf.